



Handy Ride Application Instructions

All applicants must submit a complete application which includes **both forms**

(1) *The Certification Questionnaire*

(2) *The Professional Verification Form*

STEP

1

COMPLETE The Certification Questionnaire

The Certification Questionnaire should be filled out by the applicant or the applicant's advocate. The form must be filled out in its entirety. It should be signed by the applicant or the applicant's guardian **and** anyone who assisted the applicant in completing the application.

STEP

2

COMPLETE The Professional Verification Form

The Professional Verification Form must be completed by one of the following professionals who are familiar with the applicant's condition:

- Physicians or Psychiatrists;
- Occupational Therapists;
- Psychologists;
- Physical Therapists;
- Recreational Therapists;
- Registered Nurses (RN)

To complete the *Professional Verification Form*

1. Complete and sign the Authorization to Release Information.

2. Send the *Professional Verification Form* to your designated professional.

3. Wait for your professional to return the *Professional Verification Form* to you.

Check back with your professional if you have not received the form back in a timely manner.

STEP

3

SUBMIT Both Forms Together

Submit **both** the *Certification Questionnaire* **and** the *Professional Verification Form* together to:

Mail to:
Fresno Area Express
2223 "G" Street
Fresno, CA 93706

Fax to #
(559) 457-1589

Deliver in-person to:
Handy Ride Center
4488 N. Blackstone

Manchester Transit Center
3590 N. Blackstone

STEP 4

In-Person Assessment

Usually the forms provide FAX Handy Ride Staff with all of the information needed to make a determination on eligibility. Sometimes however more information is needed. When this happens an applicant may be asked to come in for an **“in-person assessment.”**

This assessment may include:

- **A conversation about the applicant’s current mobility.** The FAX Mobility evaluator will talk with you about how you currently get around.
- **A walk outside.** This will help determine things such as physical ability to get to the regular fixed-route bus as well as memory and landmark recognition.

Please note that applicants who need to come in for in-person assessments will still have their applications processed within 21 calendar days.

Common Issues

In order to make a determination within 21 calendar days the FAX Handy Ride Center must have a complete application. There are several things which may cause an application to be incomplete. By double checking these things PRIOR to submitting your application you may avoid delays in processing.

1. **One of the forms is missing.** Your application must contain both the *Certification Questionnaire* and the *Professional Verification*. Please ensure both are submitted together.
2. **One of the forms is not signed.** Both the Certification Questionnaire and the Professional Verification must be signed. If either the applicant or the professional forgets to sign the form it is considered incomplete.
3. **The professional credentials are missing.** Professionals must include their titles and credentials when signing the Professional Verification.

Jane Doe **X** (Incomplete) Jane Doe M.D. **✓** (Complete) Jane Doe R.N. **✓** (Complete)

If FAX has not made a determination of eligibility by a date 21 days after the submission of an individuals completed application, the applicant will be treated as eligible and provided service unless and until FAX denies the application.

DATE RECVD:

FOR FAX STAFF ONLY:

EXPIRATION DATE:

Certification Questionnaire

Questions about this form?

Call FAX Handy Ride at (559) 621-5796, or California Relay at 711 for TTY.

Complete all parts of the form. Forms that are not fully completed will be returned, which will delay your eligibility determination.

PART 1

Applicant Data

Please print or type

Name: _____ ☐ Male ☐ Female
First Middle Initial Last

Birth Date: ____/____/____

Street Address: _____ Apt.#: _____

City: _____ Zip Code: _____

Day Telephone: (____) _____ Evening Telephone: (____) _____

Mailing Address (if different from above)

Street Address: _____ Apt.#: _____

City: _____ Zip Code: _____

Emergency Contact Person

Name: _____ Relationship: _____

Day Telephone: (____) _____ Evening Telephone: (____) _____

Are you currently enrolled in the FAX Special Rider program? ☐ Yes ☐ No

Have you ever been enrolled in the FAX Handy Ride program? ☐ Yes ☐ No

Do you have a California ID card or California driver's license? ☐ Yes ☐ No

What is your disability?

Explain how your disability prevents you from independently using the regular city bus.

1. Which of the following assistive devices, if any, do you use?
(Please check all that apply.)

- | | | |
|---|---|--|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Powered Wheelchair | <input type="checkbox"/> Manual Wheelchair |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Powered Scooter/Cart | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Communication Aid | <input type="checkbox"/> Portable Oxygen |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Service Animal | |
| <input type="checkbox"/> Other (please describe): _____ | | |

If you selected Wheelchair or Scooter, would you prefer/need to use the device while riding in FAX Handy Ride Vehicles? ☐ Yes ☐ No ☐ Sometimes

2. Are you able to travel in an automobile? ☐ Yes ☐ No

3. If you use a wheelchair or scooter:

Is it more than 33 inches wide? ☐ Yes ☐ No

Is it more than 51 inches long? ☐ Yes ☐ No

Is the combined weight of device and occupant more than 800 pounds?

☐ Yes ☐ No

4. Does your health condition/disability require you to use Handy Ride service:

☐ Permanently ☐ Temporarily _____ Week(s) _____ Month(s)

5. Does your health condition/disability change from day to day in ways that occasionally disrupts your ability to use regular-route city bus service?

☐ Yes ☐ No If yes, please explain: _____

PART 2

Questions about using regular-route public transit

Complete Part 2 even if you are unable to use regular-route city bus service. This information will assist us in determining how your disability/health condition affects your ability to use regular-route city bus service.

7. Do you now independently use regular-route city buses?

☐ Yes ☐ No ☐ Sometimes ☐ Yes, but only with an attendant

If "Yes" or "Sometimes," how many times? _____ per week _____ per month

Which of the following best describes how you use regular-route city buses?

☐ To travel to and from one destination only

☐ To travel to and from a few destinations

☐ To travel to and from many different destinations

8. Have you ever had training to use the regular-route city buses?

☐ Yes ☐ No

9. What is the maximum distance you are able to travel without the assistance of another person?

☐ less than 1 block (<110 yards) ☐ 1-3 blocks (110-330 yards) ☐ 4-6 blocks (440-660 yards) ☐ more than 6 blocks (more than 661 yards)

10. I can wait for a regular-route city bus (check all that apply):

☐ Only if there is a bench or shelter ☐ Up to 15 min. ☐ More than 15 min.

11. Please check all the categories below as they relate to your ability to use regular-route city buses:

I am:	Yes	No	Sometimes
A. Able to tolerate hot or cold weather (rain, humidity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Able to recognize destinations, bus stops, or landmarks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Able to tolerate air pollution (smog, fumes, perfume)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Free from night blindness (bright light, low light)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Able to recognize printed information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Able to hear and process spoken words or auditory information (background noise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Able to communicate needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Able to follow directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Able to deal with unexpected situations or changes in routine (example: bus detours)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Able to safely and effectively travel through crowded and/or complex facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Able to recognize and navigate curbs, drop-offs, curb cuts and other barriers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Able to travel independently along sidewalks and other pedestrian ways	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Able to cross streets independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. Able to find the correct bus stop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. Able to identify the correct bus (single or multiple buses during a single trip)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P. Able to get on and off a bus using the lift if necessary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q. Able to deposit fare into the fare box or show bus pass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R. Able to get to a seat/wheelchair position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S. Able to ride in a standing position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T. Familiar with what to do if I miss my bus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you checked "No" or "Sometimes" to any of the items in question 11, please explain:

Please list the addresses commonly traveled to:

Street Address: _____ Apt. #: _____

City: _____ Zip Code: _____

Street Address: _____ Apt. #: _____

City: _____ Zip Code: _____

Street Address: _____ Apt. #: _____

City: _____ Zip Code: _____

Street Address: _____ Apt. #: _____

City: _____ Zip Code: _____

PART 3 Applicant Signature

"The information you provide is confidential and will be treated as such. It will only be shared with agencies involved with FAX's eligibility determination process and other transit providers to facilitate travel in those areas, and will not be provided to any other person or agency, except as provided by the California Public Records Act." If you are determined ADA paratransit eligible, information about your eligibility status will be entered into a database maintained by Fresno Area Express.

I certify that all information on this application form is accurate. **I understand that misinformation or misrepresentation of facts will be cause for disqualification or rejection of my ADA eligibility.** I also understand that additional information relating to my health condition or disability may be required to determine eligibility. This information may be obtained through an in-person assessment or by requesting information from a professional who understands my health condition or disability. Additional information will be required only when the information provided on the application form does not clearly determine ADA paratransit eligibility.

Applicant's Signature: _____ *Date:* _____

* If the applicant is not his/her own guardian, the following information about the guardian is required:

Guardian's Name: _____

First Middle Initial Last

Day Phone: ()

Guardian's Signature: _____ Date: _____

* If someone other than the applicant or the applicant's guardian is preparing this form, please provide the following information about the preparer:

Name: _____

First Middle Initial Last

Relationship to applicant: _____

Day Phone: () _____

Preparer's Signature: _____ Date: _____

Handy Ride Eligibility Application Professional Verification

1. **Complete and sign** the “*Authorization to Release Information*”.
2. **Send** to your designated professional.
3. **Wait** for the professional to return the Professional Verification Form to you.
Check back with your professional if you don’t receive your information.
4. **Put your Certification Questionnaire and Professional Verification forms together and send to:**

Fresno Area Express
2223 “G” Street, Fresno, CA 93706
Facsimile: (559) 457-1589

SECTION A **Authorization to Release Information**

(when complete send to the professional you named)

Applicant’s Name: _____

Date of Birth: _____/_____/_____

Applicant’s Address: _____ Apt.# _____

City: _____ State: _____ Zip Code: _____

Applicant’s Telephone Number: (_____) _____

I authorize the following professional to release FAX Handy Ride specific information as requested. It is my understanding that the information released will be used solely to determine my ADA paratransit eligibility. I understand that I may revoke this authorization at any time. Unless revoked, this form will allow that professional listed below to release information described for six months after the date appearing below. All healthcare information will be kept confidential.

Name of Professional: _____ Title: _____

Applicant’s Signature: _____ *Date:* _____

Guardian’s signature required if the applicant is not his/her own guardian,

Guardian’s Signature: _____ *Date:* _____



**HAVE YOUR
HEALTH CARE
PROFESSIONAL
COMPLETE THE
REMAINDER OF THE
APPLICATION**

SECTION B Metro Mobility Professional Verification Form

This section can only be completed by a licensed professional listed on page 1 of the instructions.

Dear Health Care Professional:

The Federal Law is very specific about ADA Para-transit eligibility. You are being asked to provide information regarding this individual's disability. Eligibility is restricted to individuals who,

- 1. As a result of their disability, cannot board, ride, or disembark from a regular fixed route bus.**
- 2. Have a specific impairment related condition which prevents them from getting to or from a bus stop.**

PLEASE NOTE: This **does not** include persons who find it **difficult** or **uncomfortable** to get to and from bus stops.

In providing information you should consider only the presence of a disability or health condition and not the applicant's age or economic status.

You will be asked to include your credentials on page 13.

GENERAL INFORMATION *(Must be completed for all applicants)*

Describe diagnosed disability you are currently treating this individual for and the functional limitations of this impairment:

Date of onset ____/____/____ Date of last visit ____/____/____

How long have you worked with individual? Since ____/____/____

Is disability temporary _____ or permanent _____?

If permanent, is disability progressive? ☐ Yes ☐ No

If temporary please give best estimate of rate of recovery _____

Do temperature extremes affect the individual? (Ex. Heat index of more than 85 degrees or wind chill *less than* 32 degrees) ☐ Yes ☐ No

If yes, how so? _____

Please list all medications _____

Is this individual compliant with taking medications? ☐ Yes ☐ No

Can the individual currently use regular route public transportation? (all buses are equipped with wheelchair lifts)

☐ Yes ☐ No ☐ Not Sure

Does the individual's health condition/disability require they travel with someone to assist and/or supervise them? ☐ Yes ☐ No

Is the individual's judgment impaired? ☐ Yes ☐ No

Is behavioral inhibition impaired? ☐ Yes ☐ No

Can the individual walk? ☐ Yes ☐ No

Does the individual use a wheelchair or mobility aid? ☐ Yes ☐ No

Please list _____

How long has the individual been using the device(s)? _____

What is the maximum distance the individual is able to travel without the assistance of another person?

☐ less than 1 block (<110 yards) ☐ 1- 3 blocks (110-330 yards) ☐ 4-6 blocks (440-660 yards) ☐ more than 6 blocks (more than 660 yards)

Is/ Can/ Does the individual:	Yes	No	Sometimes
A. Able to live independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Able to seek and ask directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Able to process information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Able to follow routines (consistency)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Have basic coping skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Have basic judgment skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Have basic problem solving skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Have basic orientation skills (person, place, time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Have any concentration limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Have any short or long term memory limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Have basic orientation skill (person, place, time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VISUAL IMPAIRMENT

(Please complete if applicable to patient's disability)

Please provide visual acuity measurements and visual field readings for both eyes.

OS _____ OD _____

EMOTIONAL/BEHAVIOR ISSUES

Does the individual experience any of the following:

- ☐ Auditory hallucinations ☐ Visual hallucinations ☐ Delusions
☐ Disassociation

Does this prevent the individual from being oriented to person, place, and time?

- ☐ Yes ☐ No

Is the individual currently being treated for any of the following:

- ☐ Anxiety ☐ Depression ☐ Panic attacks ☐ Schizophrenia
☐ Other: _____

For anxiety panic attacks please indicate on average the frequency and length of panic attacks. _____ per day _____ per week _____ per month
_____ per year _____ approx. duration

PLEASE PRINT SO THAT WE MAY CONTACT YOU IF NEEDED

Name of Professional: _____

Title: _____ Professional License # : _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax: _____

Doctor/Health Care Professional Signature: _____

Please provide any additional information which may assist us in determining this applicant's eligibility:

Handy Ride staff will make the final determination on the applicant's eligibility.